The Commonwealth of Massachusetts
Department of Mental Health

DMH Continuing Care Referral for Transfer to DMH Facility

I.HOSPITAL INFORMATION

Referring Hospital: _____

Referring MD: _____

Phone: _____ Page: _____

Attending MD *(if different from above):* _____

Phone: _____ Page: _____

Hospital Social Worker: _____

Phone: _____ Page: _____

II. IDENTIFICATION

Patient Name: _____ Date: _____

Address _____
(number and street) (Apt no) (City) (State) (Zip code)

Birth Date _____ Sex _____ Race _____ Language _____
MM/DD/YY M / F Does patient speak English? ☐ Yes ☐ No

Is this patient DMH eligible? ☐ Yes ☐ No
DMH Area of Tie (if known): _____DMH Site (if known)_____
If "No" has eligibility application been filed? ☐ Yes ☐ No
Eligibility applications are available at www.state.ma/dmh . (*Please Note: an eligibility application is required for referrals who are not already DMH eligible. However, an eligibility determination is not necessary for a referral to be accepted and a transfer to occur.)*

Health Insurance

☐ No health coverage
☐ Medicaid/MassHealth Card #: _____ RID #:_____
MassHealth Plan ☐ HMO _____ ☐ PCC ☐ Psych Under 21 ☐ Other
(Name of HMO)
☐ Medicare
☐ Other Insurance Name of Insurance: _____ Policy #: _____

Name of Policy Holder: _____
Diagnosis:
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Date of Inpatient Admission: _____
MM/DD/YY

Legal Status
☐ 3 Day Hospitalization - M.G.L. c. 123, s. 12
☐ Conditional Voluntary Admission - M.G.L. c. 123, ss. 10 & 11
☐ Civil Commitment - M.G.L. c. 123, ss. 7 & 8, Exp. Date: _____
☐ District Court Rogers – 8b ☐ Probate Court Rogers

Other Legal Issues: _____

III. Brief Summary of Hospital Course:

IV. Current Clinical Status/Mental Status:

V. Risk Behaviors:

Current*	Past
___ Self Injurious	___ Self Injurious
___ Suicide Attempts	___ Suicide Attempts
___ Assaultiveness	___ Assaultiveness
___ Elopement	___ Elopement
___ Substance Abuse	___ Substance Abuse
___ Fire Setting	___ Fire Setting
___ Inappropriate Sexual Behavior	___ Inappropriate Sexual Behavior

**Provide details of any current risk(s) below:*

VI. Medications

1. Current Psychiatric Medications:

Name	Dose	Frequency	Side Effects	If Applicable Blood Level/WBC/Date*

**Last WBC & Date Required for Clozapine*

Medication Adherence? ___Good ___Needs Encouragement ___Poor

2. Discontinued Psychiatric Medications during this hospitalization:

Name	Highest Dose	When/Why Discontinued

VII. Medical History

1. Medical Problems: _____

_____

_____

_____

TB: PPD Date: _____ Result: NEG: _____ POS:____ If positive, treatment given_____

_____ REFUSED:____ Active Symptoms: YES:____ NO:_____

CXR Date: _____ Result: POS: _____ NEG: _____

Diet Restrictions? ____No ___Yes *(if yes describe)*: _____

Physical Limitations? ___ No ___ Yes *(if yes describe)*: _____

_____

2. Surgery: _____

_____

_____

***3*. Current Medical Medications:**

Name	Dose	Frequency	Side Effects	If Applicable Blood Level/WBC/Date

Medication Adherence?: ____Good _____Needs Encouragement ____Poor

VIII. Current Involvement of Community Supports: please discuss prior discharge attempts and the reasons they were unsuccessful:

_____

_____

_____

IX. Ongoing Barriers to Discharge: _____

_____

X. **Specific Problems and Target Symptoms to be Addressed by Continuing Care:**

_____

_____

_____

_____

XI. Patient Contact list *(Provide Name/Telephone of Applicable Contacts)**:***

Health Care Proxy: ☐ No ☐ Yes

Health Care Agent/Guardian:_____

Phone: _____ Page: _____

Emergency Contact: _____

Phone: _____ Page: _____

Representative Payee: _____

Phone: _____Page: _____

Case Manager: _____

Phone: _____Page: _____

Psychiatrist: _____

Phone: _____ Page: _____

Residential Services: _____

Phone: _____Page: _____

Primary Care Physician: _____

Phone: _____Page: _____

_____ M.D. Date:_____

Signature of Treating Physician Contact Information:_____

REMEMBER TO:

1. INCLUDE THE SIGNED NOTIFICATION OF TRANSFER
   http://www.dmh.state.ma.us/Intranet/forms/form_nt_3.pdf
2. INCLUDE SIGNED RELEASE OF INFORMATION FORM
   http://www.mass.gov/Eeohhs2/docs/dmh/forms/form_auth_twoway.pdf
3. **INCLUDE COPIES OF THE DOCUMENTS LISTED BELOW:**
   - Admission History and Physical Examination
   - Psychiatric Evaluation including DSM-IV Diagnosis (all five axes)
   - Any Assessments: psychosocial, psychological testing, neuropsychological testing, neurological examinations
   - Hospital Course including Treatment Plan
   - Progress Notes up to the last 30 days including labs, consultations, and radiology reports.
   - One month of Medication Administration Records (MARs) and Physician/Clinician Orders
   - Copies of pertinent Legal documents – such as Guardianships
4. PLEASE COMPLETE AN ELIGIBILITY APPLICATION FOR ANY PATIENT REFERRAL WHO IS NOT ALREADY ELIGIBLE. PLEASE FORWARD RECORDS FROM YOUR AGENCY THAT WOULD ASSIST IN THE APPLICATION PROCESS. THANK YOU.